IOWA MEDICAID

IOWA PLAN FOR BEHAVIORAL HEALTH

Proposal for a Section 1915(b) Capitated Waiver Program
Waiver Renewal Submittal

May 2003

Section C. QUALITY OF CARE AND SERVICES

Section C. QUALITY OF CARE AND SERVICES
A Section 1915(b) Waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, MCOs, PIHPs, and PAHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies: -- This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a. _X_ Summarize the results of or include as an attachment reports from the External Quality Review Organization, results from performance improvement projects, and other monitoring reports from the previous waiver period. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint, item

C.1 Upcoming Waiver Period, 1999 Waver Renewal Preprint].

RESPONSE:

- **State required the PIHP's Quality Improvement Program (QIP) to be reviewed and approved by a national accrediting body. The Iowa Plan QIP was initially accredited by the American Accreditation Health Care Commission, URAC, in November 1997. The contractor has maintained accreditation through URAC since that time, with the most recent review, in May 2002, resulting in a finding of no deficiencies and accreditation effective through June 1, 2004.**

- **In 2002, the Iowa Foundation for Medical Care conducted a medical audit with a focus on Emergency Room services under the Iowa Plan which found the following: 40 of the 168 ER visits reviewed resulted in inpatient treatment; documentation of assessment and evaluation was completed more consistently on enrollees that had inpatient treatment and those enrollees had more complex physical and mental health treatment needs; most frequent discharge plan was to follow-up with their outpatient providers; the PIHP completed a follow-up contact with 88% of enrollees after notification by the ER.**

- **The PIHP QI activities include projects for prevention and early identification. The process and outcomes for the prevention project which was conducted during the previous waiver period are described in Section IV of the PIHP's QI Report for Oct-Dec 2002, as shown below:**

  Screening for Depression among Clients with a Primary Substance Abuse Diagnosis

  Beginning in mid 2000, MBC of Iowa's QI Department gathered feedback and information for a second prevention activity. Input was received from the QI Committee, the Iowa Plan Advisory Committee, the Clinical and Community Advisory Committees, provider roundtables, Magellan corporate QI staff and other stakeholders.
  Suggestions for projects were reviewed and it was determined that the next project would screen clients with a primary substance abuse diagnosis for depression. Clients who screened positive for symptoms/risk factors of depression would be referred for additional mental health assessment and possible treatment. This concept had been discussed when formulating the original prevention project in 1999 and was one of the suggestions received from stakeholders in 2000.

The project was further defined through the QI Dual Diagnosis subcommittee. It was suggested that depression screenings be implemented with substance abuse clients in residential treatment. The subcommittee helped select a depression screening tool (the Beck Depression Inventory) and identify providers for the project. The project design was completed and planning meetings were held with the two substance abuse providers who agreed to implement the project (Community and Family Resources in Fort Dodge and Pathways in Waterloo) and with representatives from the Community Mental Health Centers in those two communities. The providers were responsible for administering the self-report screening tools, tracking the referrals, and reporting information to MBC of Iowa.

The following goals were established:

- ***early intervention for depression with individuals with a primary substance abuse diagnosis***
- ***prevention and/or reduction of the debilitating symptoms of depression through education of the risks of depression among individuals with a substance abuse diagnosis***
- ***increased referrals to and utilization of professional mental health services by clients with a substance abuse diagnosis who screen positive for depression***
- ***increased awareness among mental health and substance abuse providers of the prevalence of depression among clients diagnosed with substance abuse***
- ***education of substance abuse providers about options available to identify depression in clients diagnosed with substance abuse***
- ***improved collaboration and working relationships between mental health and substance abuse professionals treating clients with co-occurring disorders***
- ***improved communication between mental health and substance abuse providers and clients' Primary Care Physicians per Iowa Plan standards***

The Prevention Project began in January 2001 as planned with the two network substance abuse provider facilities. The six-month project concluded in June with the following results:

- ***36 Medicaid clients were identified by the providers as eligible for participation***
- ***all 36 clients were asked to participate and all signed Release of Information and Participation Agreement forms and completed the depression screening tool***

- ***of the 36 participants, 18 (50%) screened positive for symptoms of depression, significant enough to warrant referral for additional assessment***
- ***all 36 participants were given information about dual diagnosis issues and referral resources***
- ***of the 18 participants who screened positive, eight (44%) accepted a referral to a mental health provider for additional evaluation, five (28%) were already in active treatment with a provider, and five (28%) declined the referral***
- ***transportation assistance to the mental health intake appointment was provided for all eight of the participants who accepted referrals***
- ***seven of the eight clients were able to see a mental health provider within two weeks of the screening***

Additional analysis of claims data of the participants indicated that of the eight participants who accepted a referral, six had a confirmed claim paid for at least one mental health service.

The Prevention Project was well received by the two participating substance abuse providers and was viewed as a valuable activity that could be continued/expanded in their programs. It was also encouraging that the clients were all willing to participate in the activity and to complete the screening tool. Findings were reviewed in the QI Dual Diagnosis subcommittee and the QI Committee and an expansion of the project with additional providers was recommended. The project was successful in helping both clients and substance abuse providers become more aware of dual diagnosis issues and how they may affect treatment outcomes.

- **Other monitoring from the previous waiver period includes the Independent Assessment of the Iowa Plan for Behavioral Health. The Iowa Department of Human Services (DHS) Division of Medical Services contracted with William M. Mercer, Inc. to perform the Independent Assessment (IA) of the Iowa Plan. The IA focused on the core issues of: 1) access to waiver services; 2) quality of waiver services; and 3) cost effectiveness of the waiver. The IA included the following activities: compile, review, and analyze service utilization data; review of various Iowa Plan program documents, such as quality management reports, policies, and protocols; site visit to Magellan Behavioral Care of Iowa (MBC), the managed care vendor with the responsibility for managing behavioral health care for the State of Iowa under this waiver; interviews with Iowa State officials and key Iowa Plan stakeholders.**

  EXCERPT FROM EXECUTIVE SUMMARY: Mercer's overall conclusion is that the Iowa Plan clearly meets CMS guidelines and requirements in terms of access, quality, and cost effectiveness and

continues to be an exemplary program. Progress continues in areas identified during the previous IA. Our assessment found that substantial improvements in access occurred from the pre-waiver period to waiver year one, and ongoing improvements in access are evident from waiver year one to waiver year three. Improvements in the quality of waiver services are evident from Mercer's review of documents and discussions with stakeholders.

AREAS IDENTIFIED FOR IMPROVEMENT

The executive summary of the IA identified three areas for potential improvement. These are not formal recommendations of the IA and two of the areas for improvement are also listed (above) as recommendations. The areas for improvement include the following:

1) Communications with stakeholders

STATE FOLLOW-UP: State discussed this area for improvement with the IA entity and determined that this comment pertained to stakeholder concern regarding communication pertaining to a particular pilot project. There were not additional findings of concern by the IA entity in this area. State finds that the project in this situation extended over an eighteen month period of time, with the final report distributed at the January 2001 Quality Improvement Committee six months after the conclusion of the pilot. State finds that contractor provided up-dates during that period of time and has established a formal process to provide up-dates on all pilot activities at the QI Committee meetings at least quarterly. This area of concern was discussed at stakeholder meeting (QI Dec/2002; Adv. Com Dec/2002) meetings and stakeholders were encouraged to provide feedback should they feel that communications are an area of concern. Stakeholder comments tended to support the communication efforts made by the PIPH. State does not find this to be an on-going area of concern, but continues to monitor this area.

2) Potential overuse of emergency room services

The IA found that the rate of ER visits increased over the life of the waiver and recommended that the State and PIHP analyze data and/or conduct a special study to reveal a cause for the increase.

STATE FOLLOW-UP: Based on preliminary reports by the IA and prior to the issuing of the final IA report, State directed the 2002 medical audit to focus on factors that may contribute to the increased utilization of ER services and the impact on care for enrollees. The medical audit found the following: a significant number of ER visits did not result in inpatient treatment; patients with inpatient treatment needs had more complex physical and mental health treatment needs; mental health specialist or psychiatrists rarely

provides services in the ER; the Iowa Plan contractor provided a follow-up contact in 88% of ER visits reported to the Iowa Plan contractor (this exceeds the requirement for follow-up in 85% of ER visits which do not lead to inpatient treatment.). State continues to monitor the utilization of ER services and work with the PIHP to address this area of concern. State notes that the CAHPS survey undertaken in 2001 reported that only 23% of all Medicaid recipients indicate they had an emergency room visit in the prior twelve months compared to 32% for state overall.

3) Increased inpatient readmission rates for children and adolescents. The IA found that inpatient readmission rates has moderated for adults, but continue to rise for persons under age 18 and recommended that the State and PIHP analyze readmission rates for adolescents.
STATE FOLLOW-UP: State has directed that the 2003 medical audit focus on factors that may contribute to the increased inpatient readmission rates for children and adolescents. The medical audit is scheduled for completion in June 2003. State continues to monitor this area.

b.___ Intermediate sanctions were imposed during the previous waiver period. Please describe.

RESPONSE:
No sanctions were imposed.

Upcoming Waiver Period -- Please check any of the items below that the State requires.

a. X_[Required] The State has a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. Please indicate if the strategy has already been submitted to CMS. If not, please attach a copy (Attachment C.1.a).

RESPONSE:

The State's quality plan is posted on the web at www.dhs.state.ia.us/publications**. See "12/2/02 Request for Comment: Medicaid Managed Care Quality Plan"**

b._ X_[Required] The State must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy

available for public comment before adopting it in final.

RESPONSE:

The draft quality plan was presented to the Medicaid Advisory Committee and to the Managed Health Care Advisory Committee for their comment and suggestions. The Iowa Plan Advisory Committee was notified of the web site posting for their input and comment.

c. _X_[Required] The State must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy as needed.

RESPONSE:

The quality plan is reviewed every two years. The most recent review was completed in February 2003 after review by the Medicaid Advisory Committee, the Managed Health Care Advisory Committee, the Iowa Plan Advisory Committee and public comment through the web posting.

d. _X_[Required] The State must arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to the services delivered under each MCO and PIHP contract. Note: EQR for PIHPs is required beginning 8/14/03.

1. Please specify the name of the entity:

   RESPONSE:
   Iowa Foundation for Medical Care

2. The entity type is:
   (a) **X**_ A Peer Review Organization (PRO).
   (b)__ A private accreditation organization approved by CMS.
   (c)__ A PRO-like entity approved by CMS.

3. Please describe the scope of work for the External Quality Review Organization (EQRO):

   RESPONSE:
   Review the Iowa Plan waiver.

e. _X_ The State includes required internal quality assessment and performance improvement ~~(QAPI)~~ standards in its contracts with MCOs and PIHPs.

RESPONSE:

- **The Iowa Plan contract, section 47.0 required the PIHP to implement a quality assurance program which incorporates the requirements set forth in the attachment titled "Quality Assurance". See attachment C.I.a.**
- **The Iowa Plan contract establishes performance measures pertaining to quality performance.**

f._ X The State monitors, on a continuous basis, MCO/PIHP adherence to the State standards, through the following mechanisms (check all that apply):

1._ **X** Reviews and approves each MCO's/PIHP's written QAPI. Such review shall take place prior to the State's execution of the contract with the MCO/PIHP.

2._ **X** [Required] Reviews the impact and effectiveness of each MCO's/PIHP's written QAPI at least annually.

3. **X** _ Conducts monitoring activities using (check all that apply):

(a)_ **X** State Medicaid agency personnel

(b)__ Other State government personnel (please specify):

(c)__ A non-State agency contractor (please specify):

4.__ Other (please specify):

g._ X [Required] The State has established intermediate sanctions that it may impose.

RESPONSE:

The Iowa Plan contract allows for penalties for failure to meet certain conditions of performance.

h. X _ [Required] The State has standards in the State QAPI, at least as stringent as those required in 42 CFR 438 Subpart D for access to care, structure and operations, and measurement and improvement .

II. Access Standards

Coverage and Authorization of Services

Previous Waiver Period

a. _X_ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint, item C.II Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

RESPONSE:

During the previous waiver period, State monitored the following areas for compliance in the areas of coverage and authorization of services:

- **Monthly Authorization Reports: State reviewed authorization activities though the PIHP's monthly Authorization Reports (IAAU01-12) . State identified a subset of the reports for focused monitoring to identify trends or "spikes" that may alert the State to areas of concern. When State notes trends or spikes, State requests explanatory background from the PIHP at the weekly oversight meeting between State and PIHP administrative staff. Following is a sample of the State's review and monitoring:**
  - **Initial Authorizations: Number of authorizations by type of service with breakouts by rate cell. The reports show a steady pattern, no questionable trends (IAAU01)**
  - **Granted Requests: Percentage of authorizations granted at the level requested. State monitoring focuses on inpatient and found that mental health authorization rates consistently ranged from 81% to 87%. Authorization rates for inpatient substance abuse treatment ranged from 91% to 96%. Overall rates for all levels ranged 91% to 94% monthly. (IAAU02)**
  - **Non-Certifications: Reports of initial and con-current non-certifications are available in separate reports. Highest incident of non-authorization has been for inpatient mental health and remains at a steady pattern. (IAAU04-05)**
  - **Persons authorized: Reports the number of persons authorized by level of care, with breakouts by region and rate cell. State monitoring tool focuses on inpatient mental health and residential substance abuse treatment. State monitoring shows steady patterns of monthly fluctuation, no trends indicating areas of concern. (IAAU08)**
  - **Persons authorized and persons served: Separate reports show percent of enrollees authorized for services and receiving services. The report of services received is based on claims and includes**

non-authorized or pass through levels of care. (IAAU09, IAUT02)

- **Service Redirections: This report is especially informative to State, it documents the level of care authorized when the requested level of service is denied by the PIHP. The PIHP is required to always offer an alternative service when the enrollee does not meet psychosocial necessity for the requested level of care. State monitoring finds that the PIHP consistently redirects some clients to a higher level of care than requested by the provider. State considers this an indicator that PIHP is appropriately applying criteria for levels of care. (IAAU03)**

- **<u>Monthly Performance Indicator (PI) reports</u>: State reviewed the PIHP's performance indicator reports on a monthly basis. The PI that are used to monitor coverage and authorization include PI-I #3, 4, 6, PI-P # 3, PI-M #4, 5, 6, 19. See attachment Iowa Plan Performance Indicators for details. Following is a summary of key indicators:**
  - **PI documenting involuntary commitments (PI-I #3), emergency room presentations (PI-I # 6), and discharges to shelters (PI-P # 3) are intended to alert the State to whether the PIHP is providing appropriate coverage and services (State presumes that lack of appropriate services and authorizations by the PIHP would cause an increase in these indicators).**
    - **Involuntary commitments show a downward trend: 10.8% for waiver years 1-2; 8.4% for 2002; 5.6% for 2003 to-date. (PI-I #3)**
    - **ER visits have been a focus point as they averaged above the incentive target level of 8.5/1,000 for the two previous years. While the performance level has been higher than 8.5/1000, the upward trend has leveled to a steady 10/1,000 for 2002 and 2003. (PI-I #6)**
    - **Discharges to shelter were below the target upper limit of 3.5% with a range from 0.25% to 1.38% over the prior 7 quarters. (Compared to a range of 0.23% to 1.57% for waiver years 1-2) (PI-P # 3)**
  - **PI documenting the percent of enrollees access services show 14.93% of enrollees accessed services through the PIHP. On a monthly basis, 7-8% of enrollees access services. (PI-I #4 and PI-M #6)**
  - **PI-M #19 tracks the unduplicated number of enrollees accessing mental health services only or substance abuse services only or both mental health and substance abuse services. Monthly tracking shows an upward tread in the number of enrollees accessing services in each area.**

Upcoming Waiver Period -- Please check any of the following processes and procedures that the State requires to ensure that MCOs, PIHPs, and/or PAHPs meet coverage and authorization requirements.

Contracts with MCOs, PIHPs, and PAHPs:

a. _X_ [Required] Identify, define and specify the amount, duration and scope of each service offered, differentiating those services that may be available to special needs populations only, as appropriate. Note: These services may not be furnished in an amount, duration, and scope that is less than the amount, duration, and scope for the same services under the State Plan.

RESPONSE:

This waiver requirement is upheld by the Iowa Plan contract requirement that the PIHP may not limit the amount, scope or duration of covered services which are included in the State Medicaid plan unless such limitation is provided in the fee-for-service program. The PIHP is required in the Iowa Plan contract to authorize reimbursement for services when it is determined by the PIHP that there is a psychosocial necessity for mental health service or a service necessity for substance abuse treatment services.

b._ X_ [Required] Require that the MCO, PIHP, or PAHP may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;

RESPONSE:

This waiver requirement is upheld by the Iowa Plan contract requirement that the PIHP is required to authorize reimbursement for services when there is a psychosocial necessity for a covered mental health service or a service necessity for covered substance abuse treatment services and that the contractor may not deny based on covered diagnosis, type of illness or condition for a covered benefit.

c._ X_ [Required] Include a definition of "medically necessary services". This definition can be no more restrictive than that used in the State Plan. Please list that specification or definition:

RESPONSE:

Medically necessary services under the Iowa Plan are consistent with medically necessary services under the FFS program, with special consideration for mental health and substance abuse treatment care:

MENTAL HEALTH: PSYCHOSOCIAL NECESSITY is an expansion of the concept of medical necessity and shall mean clinical, rehabilitative or supportive mental health services which meet all of the following conditions:

- **appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis**
- **provided for the diagnosis or direct care and treatment of a mental disorder**
- **within standards of good practice for mental health treatment**
- **required to meet the mental health need of the enrollee and not primarily for the convenience of the eligible person, the provider, or the Contractor**
- **be the most appropriate type of service which would reasonably meet the need of the eligible person in the least costly manner**

After consideration of:

- **the enrollee's clinical history including the impact of previous treatment and service interventions**
- **services being provided concurrently by other delivery systems**
- **the potential for services/supports to avert the need for more intensive treatment**
- **the potential for services/supports to allow the enrollee to maintain functioning improvement attained through previous treatment**
- **unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g. availability of transportation, lack of natural supports including a place to live)**
- **the consumer's choice of provider or treatment location**

SUBSTANCE ABUSE TREATMENT: SERVICE NECESSITY is the requirement that the goods and services provided or ordered must be, pursuant to the criteria of the ASAM PPC2R or the PMIC Admission and Continued Stay Criteria, which ever is applicable:

- **appropriate and necessary to the symptoms, diagnoses or treatment of a covered disorder**
- **provided for the diagnosis or direct care and treatment of a covered disorder**
- **within standards of good practice within the substance abuse service area**
- **required to meet the need related to a covered diagnosis or disorder, and not primarily for the convenience of the eligible person or provider**
- **be the least costly type of service which would reasonably meet the need of the eligible person**

- **be within the scope of the licensure of the provider**

d._ X_[Required] Include written policies and procedures for the processing of requests for initial and continuing authorizations of services.

e._ X_[Required] Require that the MCO, PIHP, and PAHP have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

f._ X_[Required] Require that the MCO,PIHP, and PAHP consult with the requesting provider when appropriate.

g._ X__[Required] Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope, that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

RESPONSE:
A psychiatrist or an appropriate, qualified health care professional may deny or limit an initial or concurrent request for authorization of services.

h._ **X_**[Required] Require that, for standard authorization decisions, notice is provided as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days. The timeframe may be extended up to an additional 14 days if the enrollee or provider requests an extension or if the MCO, PIHP, and PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

RESPONSE:
For services which require prior authorization, providers may request authorization by calling the PIHP. Providers receive verbal notification of authorization during the clinical review call. Written notification is mailed with in two business days and includes the specific service authorized, number of days or sessions and data range for the authorization.

i._ **X_** [Required] Require that the MCO,PIHP, or PIHP make an expedited authorization decision no later than 3 working days after receipt of the request for service. The timeframe may be extended up to 14 days if the enrollee requests an extension or if the MCO, PIHP, or PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

RESPONSE:

Providers who disagree with the PIHPs decision to deny authorization may request an immediate clinical care review with a PIHP physician consultant, which the PIHP will provide within two hours of the clinical review call.

j.___ Other (please describe):

III. Structure and Operation Standards

Provider Selection

Previous Waiver Period

[Required for all related items checked in previous waiver request] Please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

RESPONSE:

The Iowa Plan PIHP is required to contract with any willing provider of mental health or substance abuse treatment services who is appropriately licensed, certified or accredited to provide covered services, who meet the credentialing criteria, who agree to the standard contract provisions, and who wish to participate.

- **State monitored the PIHP's credentialing activities to assure that such administrative activities did not unduly delay a providers entering the PIHP network and required the PIHP to complete the credentialing process for at least 60% of applicants within 30 days and 100% within 90 days. The PIHP's 30 day completion rate ranged from 78% to 98%, with 100% completed within 90 days. (PI-P # 9)**
- **The PIHP meet the State requirement to retain 90% of the top mental health and 85% of all substance abuse treatment providers (PI-M # 4, 5)**

Upcoming Waiver Period

The State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow. Please check any of the following processes or procedures that the State includes in its policy

a. _X_ [Required] Each MCO, PIHP, PAHP must develop and implement a documented process for selection and retention of providers.

RESPONSE:
State requires the PIHP to maintain 90% of the top mental health providers and 85% of substance abuse treatment providers. (PI-M #4, 5)

b. **_ X_**[Required] Each MCO, PIHP, PAHP must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment solely on the basis of the population served or condition treated.

RESPONSE:
State requires the Iowa Plan PIHP to contract with any willing providers of mental health services or substance abuse treatment which are appropriately licensed, certified or accredited, who meet the credentialing criteria, who agree to the standard contract provisions, and who wish to participate.

c. X__ Each MCO, PIHP, PAHP must have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

d._ X_ Each MCO, PIHP, PAHP must have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

RESPONSE:
State requires the PIHP to complete the credentialing process for at least 60% of applicants within 30 days and 100% within 90 days. (PI-P # 9)

1._ **X_** Initial credentialing

2.___ Performance indicators, including those obtained through the following (check all that apply):

(a)__ The quality assessment and performance improvement program
(b)__ The utilization management system

(c)__ The grievance system

(d)__ Enrollee satisfaction surveys

(e)__ Other MCO/PIHP/PAHP activities as specified by the State.

e.___ Determine, and re-determine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State

_____

f. _X_ Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g.___ Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

h.___ Other (please describe):

IV. Subcontractual Relationships and Delegation

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint, item C.IV Upcoming Waiver period, 1999 Waiver Renewal Preprint].

RESPONSE:

The Iowa Plan contract (section 12.0) requires that all subcontracts must meet the same standards, terms and conditions imposed on the PIHP through the prime contract. The contract further specifies that the PIHP must notify the State of any subcontracts for other that service provision. The State reserves the right to review and approve such contracts and further holds the PIHP responsible for all work performed under the contract, whether or not subcontracts are used.

- **During the initial waiver, State approved the PIHP's subcontract for administrative services under one of the non-Medicaid funding streams. (For administrative services pertaining to the IDPH funding.)**
- **No requests were made by the PIHP during first renewal waiver period.**

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the

State uses to ensure that contracting MCOs, PIHPs, and PAHPs oversee and are accountable for any delegated functions.

RESPONSE:
The Iowa Plan contract (section 12.0) requires that all subcontracts must meet the same standards, terms and conditions imposed on the PIHP through the prime contract. The contract further specifies that the PIHP must notify the State of any subcontracts for other that service provision. The State reserves the right to review and approve such contracts and further holds the PIHP responsible for all work performed under the contract, whether or not subcontracts are used. (Contract section 12.2)

In consideration of new requirements set forth in 42 CFR 438, State will up-date the Iowa Plan contract by July 2003 to specify the requirements for subcontracts which are listed in this section.

Where any functions are delegated by MCOs, PIHPs, or PAHPs, the State Medicaid Agency:

a. _X_ Reviews and approves (check all that apply):

1.___ All subcontracts with individual providers or groups

2._ **X**_ All model subcontracts and addendum

RESPONSE:
This requirement is in section 12.0 of the Iowa Plan contract.

3.___ All subcontracted reimbursement rates

4.___ Other (please describe):

b._ X_ [Required] Monitors to ensure that MCOs, PIHPs, and PAHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

RESPONSE:
The Iowa Plan contract requires that the PIHP shall not enter into arrangements for sub-capitation, case rate, or other special financial arrangements until the sub-contractors can demonstrate ability to meet the standards established for the PIHP. (section 44.0)

c._ X_ [Required] Requires agreements to be in writing and to specify the

delegated activities.

d._ X_[Required] Requires agreements to specify reporting requirements.

e._ X_[Required] Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

f._ X_ [Required] Ensures that MCOs, PIHPs, and PAHPs monitor the performance of the entity on an ongoing basis.

g._ X_[Required] Monitors to ensures that MCOs, PIHPs, and PAHPs formally review the entity's performance according to a periodic schedule established by the State.

h._ X_[Required] Ensures that MCOs, PIHPs, and PAHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

i._ X__ [Required] Requires MCOs, PIHPs, and PAHPs to take corrective action if any deficiencies or areas for improvement are identified.

j.___ Other (please explain):

V. Measurement and Improvement Standards

Practice Guidelines

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint].

RESPONSE:

The Iowa Plan contract (Section 42.0) allows the PIHP to develop utilization management guidelines which are approved by the State and consistent with administrative rules for the Iowa Plan (IAC Section 441.88). All such guidelines must be distributed to all network providers at least 30 days prior to effective date. The PIHP distributes the utilization management guidelines and provider manuals to all newly contracted providers.

State monitors changes in guidelines, timeliness of notice to providers (PI-P #10) and levels of compliance:

- **The level of care criteria for substance abuse treatment was up-dated to be consistent with up-dated national criteria in the American Society of Addiction Medicine's Patient Placement Criteria 2-Revised.**
- **Based on consistency of provider compliance with service guidelines, the PIHP lifted the requirements for pre-authorization of two services: Community Support Services-Low Level; and electro-convulsive therapy.**

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that MCOs, PIHPs, and PAHPs adopt and disseminate practice guidelines.

RESPONSE:
In consideration of new requirements set forth in 42 CFR 438, State will up-date the Iowa Plan contract to specify the requirements listed in this section.

a. _X_ [Required] Guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

b._ X_ [Required] Guidelines consider the needs of the MCO's, PIHP's or PAHP's enrollees.

c._ X_ [Required] Guidelines are developed in consultation with contracting health professionals.

d._ X_ [Required] Guidelines are reviewed and updated periodically.

e._ X_ [Required] Guidelines are disseminated to all affected providers, and, upon request to enrollees and potential enrollees.

f._ X_ [Required] Guidelines are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g.___ Other (please explain):

Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a. **_X_** [Required for all elements checked in the previous waiver submittal]

Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint, item C.VII Upcoming Waiver Period, 1999 Waiver Renewal Preprint]. Please break down monitoring results by subpopulations if available.

RESPONSE:

Results of State monitoring and oversight of the PIHP's quality assurance plan are described below:

1. Medical audit: -- The Iowa Foundation for Medical Care conducted a medical audit of the Iowa Plan in April-June 2002. The nature and finding from this audit is described in this document at C.I.a, item #2.

2. Periodic recipient surveys:

- **The PIHP survey which covered the period of July 2001 through June 2002 was mailed to 3,179 adults and 2,183 children/adolescent enrollees with a 21% (adults) and 18% (children/adolescents) response rate. Overall satisfaction for responders was 86% for adults and 90% for children/adolescents.**

3. Review of written quality assurance plan: State reviewed the QI Work Plan monthly and approves the QI Plan annually.

4. Review of numerical data: State reviews all monthly and quarter data reports. In addition, State has developed a monitoring tool to detect trends or spikes in certain key areas. All reports have been timely, and no problem trends have been noted through the tool.

5. On-site monitoring of quality management activities: State routinely monitors the IQP through attendance of monthly QI Committee meetings.

6. Independent Assessment: The State contracted with William M. Mercer to conduct the second Independent Assessment of the Iowa Plan. The reported findings are summarized in this document at C.I.a, item #4.

7. Performance Indicators: The State monitored 46 performance indicators which includes three categories of Performance Measures

- **PI-I: Establish target levels of achievement which are above the past established level of performance.**
- **PI-P: Establish minimum levels of performance.**
- **PI-M: Measure performance in areas consistent with the values and vision of the Iowa Plan. May or may not designate a desired level of**

performance

b. _X_ The State or its MCOs and PIHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two year period.

RESPONSE:

During the previous two year period the PIHP conducted the following focused studies:

- **One study conducted during the previous two year period by the PIHP focused on high need/high risk clients and was designed to measure functional improvement and the relationship between outcomes and provisions of services provided by the Plan. In this study, the PIHP measured changes in the functioning of enrollees at periodic intervals and reviewed the impact of Iowa Plan services on functional levels.**

  The findings from the study showed that 53% of clients either showed an improvement in functioning or remained the same. The remaining 47% showed a decline in functioning, however, 83% of the declining scores declined by 10 or fewer points. The findings appeared to reflect and confirm the serious and persistent nature of the symptoms of adult clients meeting High Need status.

  See attachment to Section C.V titled Functional Assessment of High Need Populations for details. (Excerpt from QI Annual Report, August 2002)

- **The PIHP initiated another study as a pilot prevention project to screen for depression among clients with a primary substance abuse diagnosis. The study began with feedback and information from the Iowa Plan Advisory committee, the Clinical and Community Advisory Committee, provider roundtables and other stakeholders. The study focused on clients receiving residential substance abuse treatment services who screened positive for symptom/risk factors of depression. Findings: 50% of the enrollees screened had symptoms of depression significant enough to warrant referral for additional assessment; 44% of those accepted a referral; 28% were already engaged with a mental health provider; 28% declined referral. Follow-up discussion with participating enrollees and providers indicated that the project was successful in helping enrollees and provider become more aware of dual diagnosis**

issues and how they may affect treatment outcomes. For more detail, see attachment to C.V, titled Iowa Plan Prevention Project #2.

- **The PIHP conducted focused reviews of Targeted Case Management (TCM) services. The focused review began in January 2002 and included review of 750 records from 63 TCM providers. In preparation for the focused review the PIHP developed utilization management guidelines for targeted case management in consultation with providers. After review and approval of the UM guidelines by Clinical and Community Advisory committee and State, the PIHP initiated a pilot review in January 2002 of TCM service for enrollees who received no other paid service through the PIHP for the prior twelve months. The pilot review found 49% of the cases met the guidelines. Upon review of the findings, providers and other stakeholders expressed concern regarding the guidelines. In consideration of the stakeholders' concerns, the findings from the PIHP's pilot focused review and the findings from the review of TCM by IFMC in 2001, State worked with the PIHP, provider and other stakeholders to implement administrative rules and a prior approval process used by both the Department and the PIHP. The administrative rules and the prior approval process went into effect in March 2003. For more detail regarding the findings from the PIHPs review, see attachments to C.V pertaining to Targeted Case Management.**

Upcoming Waiver Period- The State must require that each MCO and PIHP have an ongoing QAPI for the services it furnishes to its enrollees.

a. **_X_**[Required] The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's QAPI. This review includes:

1._ **X**_ The MCO's and PIHP's performance on the standard measures on which it is required to report.

2. **X**__ The results of each MCO's and PIHP's performance improvement projects.

b. ___Please check any of the following processes and procedures that the State includes as a requirement for MCO and PIHP QAPIs

Each MCO and PIHP must have::

1._ **X**_ A policy making body which oversees the QAPI

RESPONSE:

The Iowa Plan Advisory Committee reviews and provides input on the PIHP's quality assurance work plan and reviews outcomes of QI interventions.

2._ **X**_ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

RESPONSE:
Contract requires the QAP to be staffed by PIHP staff dedicated to monitoring and evaluation of services provided, who have the responsibility and authority to address any deficiencies found.

3._ **X**_ Active participation by providers and consumers

4.___ Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5.___ Other (please describe):

c. _X__[Required] Each MCO and PIHP must have in effect mechanisms to detect both underutilization and overutilization of services. Please describe these mechanisms:

RESPONSE:
The PIHP is required to report monitoring of indicators of access and availability quarterly as part of the QI Quarterly Report. The report addresses utilization through the following: review of penetration rates based on claims paid; penetration rates by diagnostic category; penetration rates by county and analysis of under-served populations by geographic areas; access to outpatient mental health providers; geographical access standards; timeliness standards. See attachment to C.V for sample report.

d. **X** _ [Required] Each MCO and PIHP must have in effect mechanisms to assess the quality and appropriateness of care furnished to **enrollees with special health care needs.** Please describe these mechanisms:

RESPONSE:

- **The PIHP identifies at risk clients based on clinical criteria established with input from the Iowa Plan Advisory Committee and other stakeholders and provides specific management procedures to ensue continuity of care including the following: review of all authorizations to assure on-going services; specified contact with providers and, when**

appropriate, the client to ensure engagement in clinically appropriate services; coordination of interventions to ensure continuity of services and to assess client functioning status.

- **Monitor quality and appropriateness of care through on-going monthly reports which break out the special needs populations: initial and concurrent authorization; service redirections; appeals; lengths of stay; clients receiving services by level of care**

e._ X__[Required] Each MCO and PIHP must measure and report to the State its performance, using standard measures required by the State. Please list or attach the standard measures currently required.

RESPONSE:

State established three categories of Performance Measures

- **Performance Indicators with Incentives (PI-I): Establish target levels of achievement which are above the past established level of performance.**
- **PI-Penalties (PI-P): Establish minimum levels of performance.**
- **PI-Monitoring (PI-M): Measure performance in areas consistent with the values and vision of the Iowa Plan. May or may not designate a target level of performance. State uses monitoring PIs, to track and establish baseline levels of performance.**

For indicators that do not meet goals, the PIHP initiates focused QI activities to assess related issues and identify effective solutions.

Performance Improvement Projects

f. _X_ [Required] Each MCO and PIHP must conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

g.___ Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

h. _X__[Required] Each MCO and PIHP must report the status and results of each project to the State as requested.

Please list or attach the projects currently planned for each year of the

waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

RESPONSE:

- **The PIHP will conduct a study which builds on Iowa Plan Prevention Project #2 and will focus on screening for depression among clients with a primary substance abuse diagnosis. The study is based on feedback and information from providers, Iowa Plan Advisory Committee, and other stakeholders. The study will focus on clients receiving residential substance abuse treatment services who screen positive for symptom/risk factors of depression.**
- **The PIHP will continue new phases of the more formal study to evaluate the cost benefit of Intensive Psychiatric Rehabilitation (IPR). This study is co-lead by the Boston Center for Psychiatric Rehabilitation. IPR services are designed to assist persons with Severe and Persistent Mental Illness to overcome disabilities pertaining to living, working, learning, and social environments and is considered an important adjunct to mental health treatment services. The study uses a tool kit to measure outcomes across a number of domains or life areas including hospitalization. The study examines types of mental health services, units of service, length of hospital stay and dollars paid. The study strives to examine whether IPR impacts other service utilization. See attachment to Section C.V titled Intensive Psychiatric Rehabilitation Services Outcome Study.**

i. **_X_** [Required] Each MCO and PIHP must measure performance using objective quality indicators.

j. **_ X_**[Required] Each MCO and PIHP must implement system interventions to achieve improvement in quality.

k._ X_[Required] Each MCO and PIHP must formally evaluate the effectiveness of the interventions.

l.____Each MCO and PIHP must correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

m.___MCOs or PIHPs are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

n.___ Each MCO and PIHP must select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

o.___ Each MCO and PIHP must select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

p.___ Each MCO and PIHP must provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

q.___ Each MCO and PIHP must establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

r.___ Each MCO and PIHP must use a sampling methodology that ensures that results are accurate and reflective of the MCO's or PIHP's enrolled Medicaid population.

s.___ Each MCO and PIHP must use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

t.___ Each MCO and PIHP must ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

u. _X_ Other (please describe):

<u>RESPONSE</u>:
State's requirements for the PIHP on quality assurance are listed below (from the Iowa Plan contract)

- **Issues raised by stakeholders shall be incorporated into the Contractor's quality assurance program (Contract section 46.0)**

- **Following are excerpts for the Iowa Plan contract attachment on quality assurance:**
  The Contractor shall implement a comprehensive quality assurance program which incorporates ongoing review of all major areas of the

Contractor's responsibility in operating the Iowa Plan. The Plan shall require the Contractor to take action to correct all changes indicated by the findings of the Quality Assurance process or by other monitoring processes implemented by the Contractor, the Departments or entities performing evaluation/monitoring on behalf of the Departments.

1 Quality assurance program staffed by persons dedicated only to the monitoring and evaluation of services provided; staff with QA responsibilities shall have responsibility and authority to address any deficiencies found

3 By the end of the second full contract year, the Contractor's QA program shall be reviewed and approved by a national accrediting body such as the National Committee on Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, the American Accreditation Health Care Commission

4 Program incorporates the principles of continuous quality improvement and takes corrective action whenever indicated

5 Program assesses the clinical impact of services provided

6 Contractor shall review GAF scores and the findings of scales administered by network providers to assess the changes in functioning of selected Iowa Plan enrollees to whom they are providing treatment. Longitudinal assessment using the clinical scales shall be done at intervals recommended by the scales selected

7 Administration no less than semi-annually of client satisfaction/ quality of life surveys with results provided for separate program components as well as overall

7.1 The Contractor shall conduct at least one satisfaction study using consumers who have been trained to do system evaluation, providing the Division of MH/DD has conducted sufficient training to make available enough trained consumers to conduct such a study

8 Administration no less than annually of a provider satisfaction survey with results provided for separate program components as well as overall

9 Analysis of outcomes of clinical record reviews and/or provider training conducted at provider sites including findings of retrospective treatment reviews required on substance abuse services

10 Summary of critical incidents reported by network and non-network providers as well a report of actions taken

11 Analysis of the subjects and outcomes of care reviews and complaints/grievances including timeframes required to reach resolution; action taken in response to trends detected

15 Assessing the impact of programs funded through the Contractor for mental health-related programs of prevention, early intervention and outreach (Medicaid-funded only)

18 A process for soliciting recommendations from consumers for subsequently assessing whether any changes in policies or procedures should be made based on the recommendations. The process also will track the recommendations made and whether and how they ultimately affect Iowa Plan policies and procedures

VI. Health Information Systems

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

RESPONSE:
Designated monitoring checked in the previous waiver renewal request:

- **The State Medicaid fiscal agent reviews Iowa Plan encounter data for completeness, logic and consistency with requirements. State monitors monthly per reports from the fiscal agent. Error rates for completeness and usability of data routinely are below 0.1%.**
- **The PIHP conducted on-site retrospective review of 196 mental health provider clinical records and 113 substance abuse treatment provider records. Part of the review included the determination of appropriateness and accuracy of information submitted by the provider.**
- **Monthly data reports pertaining to authorization (IAAU reports) and utilization (IAUT reports) were generated by the PIHP timely and in the format required by State. Samples of the type of reports generated are referenced throughout this document.**
- **The monthly performance indicator reports were generated timely. The integrity of the PI-I and PI-P reports was reviewed by the Independent Assessment entity and found to accurately reflect the performance of the PIHP.**

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the

State requires to ensure that contracting MCOs and PIHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program.

The State requires that MCO and PIHP systems:

a. _X_ [Required] Provide information on

1._ **X**_ Utilization,

RESPONSE:
Monthly data reports (IAUT01-03) and Quality Improvement Reports, Section I – Access and Availability

2._ **X**_ Grievances and appeals,

RESPONSE:
Monthly data reports (IACS01-06) and Quality Improvement Reports, Section III – Assuring Clients Rights and Responsibilities

3.___ Disenrollment for reasons other than loss of Medicaid eligibility.

b._ X_ [Required] Collect data on enrollee and provider characteristics as specified by the State.

RESPONSE:

- **Monthly data reports pertaining to authorization and utilization**
- **Provider profiling reports**

c._ X_ Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO/PIHP is capable of (please check all that apply):

1._ **X** [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees

2._ **X** [Required]Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors

RESPONSE:
The PIHP reviews whether billed services were actually provided as part of their on-site retrospective review of provider clinical records.

3._ **X** [Required] Verifying the accuracy and timeliness of data

4._ **X** [Required] Screening data for completeness, logic and consistency

RESPONSE:
The State Medicaid fiscal agent reviews Iowa Plan encounter data for completeness, logic and consistency with requirements. State monitors monthly per reports from the fiscal agent.

5._ **X** [Required] Collecting service information in standardized formats to the extent feasible and appropriate

6.___ Other (please describe):

d. _X_ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1._ **X** Health services (please specify frequency and provide a description of the data and/or content of the reports)

RESPONSE:
Monthly data reports pertaining to authorization (IAAU01-12) and utilization (IAUT01-03)

2.___ Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports)

3.___ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)

4._ **X** Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

RESPONSE:
The PIHP will report data monthly on 44 performance indicators (for SFY 2004) covering such areas of access, consumer involvement, community tenure, involuntary hospitalization, service array, quality of care. (PI-I-all, PI-P-all, PI-M #12, 15, 16, 20, 21, 23, 24, 25.)

e. _X_ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAPI.

RESPONSE:
Examples include the monthly QI Work Plan progress report

f.___ Ensure that information and data received from providers are accurate, timely and complete.

g._ X_ Allow the State agency to monitor the performance of MCOs/PIHPs using systematic, ongoing collection and analysis of valid and reliable data.

RESPONSE:
Examples include the monthly data reports , Performance Indicator reports and quarterly QI Reports.

h.___ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i. _X_ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs/PIHPs.

RESPONSE:
The PIHP has successfully submitted encounter data on a monthly basis since 1999. The Medicaid fiscal agent receives the data, reviews the data for completeness and usability and loads the data into a data base for use by State. During the prior waiver period, the PIHP failed to pass the error check on only one occasion, for data submitted in February 2002. Review of the situation determined that the majority of errors pertained to codes used by the PIHP which were not recognized by the error check as valid codes. The situation was corrected, data was resubmitted, and no further problems have been noted.

j.___ The State uses information collected from MCOs/PIHPs as a tool to monitor and evaluate MCOs/PIHPs (i.e. report cards). Please describe.

k.___ The State uses information collected from MCOs/PIHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PHPs and/or providers). Please describe.

l.___ Other (please describe):